



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
5501 S MCCOLL RD
EDINBURG TX 78539

Respondent Name

Texas Mutual Insurance Co

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-14-1093-01

MFDR Date Received

December 16, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: \$402.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. DOCTORS HOSPITAL AT RENAISSANCE provided emergency department services to the claimant on the date above. 2. Texas Mutual declined to issue payment as the documentation of the treatment failed to substantiate an emergency as defined by Rule 133.2(a)(4)(A) ."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2013	Outpatient Hospital Services	\$402.34	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.2 defines an emergency.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
 - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2
 - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Does the disputed service(s) meet the definition of emergency service?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code, 899 – “DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2”. 28 Texas Administrative Code §133.2(4)(A) states that, “a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient’s health or bodily function in serious jeopardy, or (ii) serious dysfunction of any body organ or part.” The medical documentation does not meet the definition of an emergency pursuant to §133.2(4)(A). For example:
 - a. DOCTORS HOSPITAL AT RENAISSANCE COMPLETE RECORD , Page 28
 - b. Pain: 10
 - c. SEVERITY: Maximum severity of symptoms moderate. Currently symptoms are moderate.
 - d. TIME COUSE: Sudden onset of symptoms. There has been no change in the patient’s symptoms over time.
 - e. TRIAGE NOTES: Presented to ER w/ complain of sever back pain onset x 1 week...

The review of the medical documentation that states the injured worker’s pain to be “moderate” and onset was x 1 week. These do not meet the definition of Rule 133.2(a)(4)(A) that requires “severe pain” and “sudden onset”. The Division concludes the denial code 899 is supported.

2. Requestor did not support definition of medical emergency. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$0.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February , 2013 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 Texas Register 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.